R E P O R T R E S U M E S

ED 014 728 CG 000 059

APPLICATIONS OF BEHAVIOR THEORY TO SOCIAL CASEWORK.
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EDRS PRICE MF-$0.25 HC-$1.12 26P.

DESCRIPTORS- *BEHAVIOR THEORIES, LEARNING THEORIES, *CASEWORKER APPROACH, *PSYCHOTHERAPY, *THERAPEUTIC ENVIRONMENT, *STIMULUS BEHAVIOR, BEHAVIORAL SCIENCES, SOCIOLOGY, CONDITIONED STIMULUS, OPERANT CONDITIONING, SOCIALLY MALADJUSTED, COUNSELING, SOCIAL WORKERS, COUNSELOR ROLE,

BEHAVIOR THEORY CAN FORTIFY SOCIAL CASEWORK BY PROVIDING PRACTICAL LINKS BETWEEN THE IDENTIFICATION OF THE CLIENT IN DISTRESS, THE DELINEATION OF CLINICAL GOALS, THE FORMULATION OF PLANS OF INTERVENTION, AND THE MEASUREMENT OF OUTCOME. THESE BASIC ASSUMPTIONS IN THE BEHAVIORAL APPROACH ARE IMPLICIT IN THE STRUCTURE TREATMENT--(1) ALL SOCIAL BEHAVIOR IS LEARNED AND CAN BE MODIFIED, (2) ALL PSYCHOTHERAPIES INVOLVE A TEACHING AND LEARNING EXPERIENCE, AND (3) A MORE DELIBERATE APPLICATION OF LEARNING PRINCIPLES TO PSYCHOTHERAPY WOULD YIELD MORE EFFECTIVE RESULTS. AT THE OUTSET OF THERAPY, A CONTRACT IS FORMED AND GOALS SELECTED. THE THERAPIST DEVELOPS A TREATMENT PLAN, EXPLAINS ITS RATIONALE, AND MANAGES THE HIGHLY STRUCTURED THERAPEUTIC INTERCHANGE. BEHAVIOR ASSESSMENT OF STIMULI AND RESPONSES IS MADE OF DIRECTLY RELEVANT AND OBSERVABLE DATA. THE BEHAVIOR THERAPIST USES RESPONDENT AND/OR OPERANT THERAPY TO ALTER THE ENVIRONMENT AND/OR RESPONSES TO STIMULI. A CASE IS DESCRIBED TO ILLUSTRATE THIS APPROACH. TECHNIQUES OF BEHAVIOR THERAPY MIGHT BE EXTENDED TO UNMOTIVATED, SOCIALLY DISADVANTAGED CLIENTS, PUBLIC ASSISTANCE PROGRAM PARTICIPANTS, AND CLIENTS IN CORRECTIONAL SETTINGS AND CHILD GUIDANCE AGENCIES. EVERY AREA OF SOCIAL BEHAVIOR MAY BE MODIFIED BY APPLICATION OF LEARNING PRINCIPLES. (PR)

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ED014728

Applications of Behavior Theory to Social Casework

Richard B. Stuart

As a scientifically based helping profession, social casework can fortify its practice with the adaptation of an empirically corroborated theory pertaining directly to the maintenance and change of behavior. Behavior theory is such an approach. It provides a clear series of practical links between the identification of client distress, the delineation of clinical goals, the formulation of plans of intervention and the measurement of outcome. The material which follows will characterize the basic elements of behavioral theory relevant to casework in the areas of the structure of treatment, the nature of behavioral assessment, and the nature of intervention. A case will then be described to illustrate this approach.

Structure of Treatment

There are three basic assumptions in a behavioral approach to casework. The first is that all social behavior is learned and can be modified through the application of the principles of learning.[1] The change process begins with a precise description of problem behavior

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and then leads to a planful alteration of the controlling conditions and contingencies of behavior. There are no mentalisms and internal mechanisms in the assessment and no hypothetical constructs in the logic of the plans of change. Furthermore, it is believed that there is no class of learned behaviors which cannot be altered through the application of learning principles.

The second basic assumption of the behavioral approach is that all psychotherapies involve a teaching-and-learning experience for therapist and client, respectively. To deny this is to deny the commonplace observation that the therapist rewards the client with attention and approval, when adaptive efforts consistent with the therapist's guidance are manifest, or that attention and approval are withdrawn when the expected adaptive strivings are not present. In fact, it has been suggested that it is impossible for two people to interact without influencing (controlling) each other. An examination of this supposition recently demonstrated that despite strong beliefs in therapist neutrality, when Carl Rogers offered 85 nondirective interviews to a client, he differentially rewarded and increased the frequency of certain client behaviors through the selective application of empathy, acceptance and directiveness.[2]

If learning is inevitable in psychotherapy, the third assumption of behavior therapy is that "a more deliberate application of our knowledge of the learning process to psychotherapy would yield far more effective

results."[3] Learning is used here in its broadest context, including the acquisition, maintenance, alteration and elimination of behavior. While the direct application of laboratory principles to in vivo situations is not without hazards, much can be learned from laboratory and field studies of learning which can enhance the attainment of therapeutic objectives. Explicit application of these principles may increase therapeutic effectiveness[4] and provide the opportunity to forestall violations of therapeutic morality which arise when therapists influence patients without their own or their patients' acceptance of this fact.

Goal Determination

All behavioral treatment is goal oriented, and nothing occurs during the therapeutic interchange which is not relevant to the attainment of goals. Society assumes the right to determine the behavioral change goals with certain categories of clients such as children, psychotics and offenders. While these clients may not participate in goal determination, it is essential that they become aware of the therapeutic goals as soon as practical. (It is recognized that the term "practical" suggests a broad range of variance, as determined in individual treatment situations.) With all other clients, a therapeutic contract is formed in which:

> "...the therapist is the agent of the patient, and undertakes to treat only what is specifically determined jointly by the patient and therapist."[5] (Italics mine.)

Thus the goals are a product of mutual assent, they are explicit and they are ammenable to periodic monitoring by both client and therapist. Mutuality assures commitment to goal attainment by the client and therapist. Explicitness creates the condition necessary for precise treatment planning. Finally, monitorability allows both the client and therapist to have immediate information about the effectiveness of their efforts so that adjustments in the plan are possible.

Relationship

The therapist-client relationship is the matrix through which treatment is administered in behavioral treatment as in all individual therapies. Two therapist tasks deserve mention in this connection. First, the therapist assumes directive responsibility throughout the treatment, and second, the outcome of treatment is the responsibility of the therapist. As Wolpe and Lazarus observe:

> "Just as the unlearning of the experimental neurosis is completely in the control of the experimenter, so the overcoming of human neurosis is within the control of the therapist through techniques quite similar to those used in the laboratory."[6]

The therapist undertakes to aid the client in formulation of his goals

and then develops a treatment plan consistent with these goals. He explains the rationale for the plan so that this didactic component of treatment is as explicit as the goals and treatment plan. He then assumes responsibility for managing the highly structured therapeutic interchange in order to exclude material not pertinent to the attainment of goals or their modification.

The second task of the therapist is to increase the attractiveness of treatment for the client; that is, to increase the client's willingness to participate in the behavior change operation. Procedures used to achieve this goal include descriptions of probable outcomes and selective use of rewards. These and others are well described elsewhere.[7]

Adaptive versus Maladaptive Behavior

Behavior therapists accept the view that deviance is defined by the community with which the individual interacts. Adaptive behaviors must be compatible with community expectations and with the attainment of individual goals. Maladaptive behaviors are either incompatible with community expectations or individual goals, or both.

The behavior therapist is concerned with two aspects of behavior: its frequency and its controlling conditions. When the behavior of autistic children is studied,[8] it is seen that maladaptive behaviors,

such as atavisms, occur at very high relative frequencies while adaptive behaviors, such as social responses, occur at correspondingly low frequencies. The behaviors of normal children, conversely, contain high frequencies of adaptive behaviors and low frequencies of maladaptive behaviors. A second feature which differentiates the repertoires of autistics and normals is the relative infrequency of socially mediated behaviors among the former group as opposed to the relative frequency of such behaviors in the latter group. Large segments of the behavioral repertoire of autistics is maintained by concrete reinforcers. Among normals, concrete reinforcers are important but social reinforcers control large sectors of the repertoire. Increasing the frequency and range of socially mediated behaviors is one of the chief means through which the frequency of adaptive behaviors is increased. This process is enhanced by the fact that in any individual, adaptive and maladaptive behaviors coexist.[9]

Controlling Conditions of Behavior

From a behaviorist's point of view, all human behavior is a result of the individual's responses to internal and external stimuli. Behavior is said to be maladaptive when it is "elicited under inappropriate stimulus conditions," although the same behavior may be adaptive under

different conditions.[10] The following instances illustrate several categories of maladaptive behavior considered in the light of stimulus conditions:

1. Problems of Inappropriate Stimulus Control -- situations in which the behavior occurs in response to the wrong stimuli. Psychosomatic illness, in which profound psychophysiological stress may result from social stimuli, and anxiety reactions in which responses appropriate to noxious stimuli are elicited in response to neutral stimuli, are two examples.

2. Problems of Lack of Stimulus Control -- situations in which responses normally under the control of some stimulus fail to occur. The failure of an enuretic child to awaken in response to the autonomic stimulus of bladder distension is an illustration of this category.

3. Defective Stimulus Control -- occurs when stimuli control certain categories of response some of the time, but not the entire response class all of the time. For example, antisocial behavior such as stealing may sometimes occur despite the existence of verbal proscriptions.

4. Inadequacies in the Individual's Reinforcing System -- occur when learning experiences have not provided the opportunities for development of reinforcing stimuli appropriate for behavioral control. For example, Ferster has attributed large segments of the maladaptive behavior of autistic children to their failure to be taught the salience of social mediation. Invalidism as a response to physical illness may similarly be a consequence of the patient's failure to respond to reinforcers which, for most persons, control behavior defined as not being an invalid.

5. Presence of Inappropriate Reinforcers -- occurs through "improper learning." In these situations, commonly corollaries of each of the above categories, the individual learns to derive gain for maladaptive responses. For example, the anxiety of the psychotic may be reduced through conversations with imaginary, supportive voices.

Behavior Assessment

Assessment in behavior therapy serves the same function as diagnosis in psychotherapy -- the collection of data adequate for the formulation of a treatment plan. Behavior assessment differs from diagnosis in at least two respects. First, behavior assessment relies primarily on the identification of observable behaviors, observable reinforcements and testable inferences about response strength and response flexibility. There are no inferences as to covert psychological structures, motivational concepts in the dynamic sense or other mentalistic formulations. Second, behavior assessment is directed exclusively toward the collection of data relevant to the solution of problems which are discussed in the treatment contract with the client. The social history common to traditional social casework practice is eschewed because it both leads to the collection of vast quantities of irrelevant data and it delays the onset of specific problem-solving activities.

Behavior assessment seeks to collect data in two general areas. First, it seeks to identify the precise nature of problem relevant behavioral responses (R). Criteria for determining the limits of such behavior are somewhat ill-defined as yet, but the behavior in question must be related to that which is involved in the attainment of the client's goals. Second, behavior assessment seeks to identify the stimulus conditions under which the responses currently occur and can be expected to be modifiable. For describing the conditions under which problematic respondent behavior occurs, it is necessary to identify the eliciting stimuli (S^E). For describing the conditions under which problematic operant

behavior occurs, it is necessary to identify the discriminative stimuli (S^D) and the reinforcing stimuli ($S^{R\pm}$). In summary, the data collected must be sufficient to complete the following symbolic statement:

$$\begin{matrix} S^E \\ \Big\downarrow \\ S^D \end{matrix} \quad R \longrightarrow S^{R\pm}$$

As can be observed, most traditional diagnostic categories are not relevant to behavior assessment. Where categorization occurs, responses are identified as adaptive, maladaptive or missing, while stimuli are identified in the light of their sufficiency for controlling adaptive behavior. Each client is evaluated in light of the ideographic properties of his behavior, beginning with the identification of maladaptive or problem behaviors relevant to specific goals, as determined by the client and significant others in his environment, and then moving toward identification of the steps essential to the attainment of these goals.

Processes of Behavior Change and Maintenance

All behavior, adaptive and maladaptive, occurs through the operation of at least two fundamental processes, respondent and operant conditioning. These processes "usually occur simultaneously but involve different responses."[11] Respondent conditioning is concerned with the formation of new stimuli for eliciting reflexes already in the individual's repertoire. The reflexes are part of, and are mediated by, the autonomic nervous system through the smooth muscles and glands. In respondent

conditioning, the individual learns to respond reflexively to stimuli which did not previously have the capacity to elicit the reflex. The classical example of respondent conditioning is the experiment by Pavlov who trained a dog to salivate (reflex) when a tone (conditioned stimulus) was sounded, after the tone was previously paired with a taste of food powder (unconditioned stimulus). Both the tone (CS) and the food powder (UCS) are eliciting stimuli. Eliciting stimuli are necessary and sufficient conditions for respondent behavior, functioning as triggers for autonomic responses. In most instances a single stimulus yields a single response of comparable intensity, with the impact of the response being seen as changes in internal physiology which are generally behaviorally observable.

The respondent behavior most commonly brought to the attention of the social worker is anxiety. The anxiety occurs in a situation in which an initially neutral stimulus comes to elicit the reaction commonly associated with a noxious stimulus.[12] For example, one who has experienced pain in the dentist's office may experience anxiety when exposed to the eliciting stimulus configuration (dental apparatus) which was contiguous with the experience of pain. Anxiety is difficult to overcome because it commonly leads to avoidance responses. In order to avoid the experience of anxiety, the man who fears dentists may not enter a dental office. As long as his avoidance behaviors persist, he is denied the opportunity to learn that his fear may be unfounded. His avoidance behavior is maintained by the fact that it results in the removal of an aversive stimulus -- the experience of anxiety. To complicate matters further, it is characteristic

of anxiety responses that they readily generalize to stimuli similar to those associated with the origin of the anxiety.

One way to overcome anxiety responses is through the process of counter-conditioning. This is a process designed to neutralize the conditioned association between stimuli when the continued association interferes with adaptation. Wolpe has stated the principle underlying this treatment as follows:

> "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli, so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety will be weakened."[13]

Systematic desensitization is a form of respondent conditioning derived from this principle. In systematic desensitization, the client is trained to relax deeply. He is then presented with feared stimuli in increasing intensities, beginning with very mild presentations. He cannot be both relaxed and anxious at the same time and relaxation predominates because the aversive stimuli are presented at low intensities and, for each presentation, the incompatible relaxation responses are stronger. The associations between neutral stimuli and anxiety reactions can be overcome in this manner as new relaxation responses are conditioned to the formerly aversive stimuli. Furthermore, it has been shown that these changes are generally carried over into normal life situations.

As employed in treatment, respondent conditioning takes many forms.

It may be used to reduce anxiety, as in treatment to overcome phobias, or it may be used to induce anxiety, as a means of inhibiting antisocial or self-destructive behaviors, such as homosexuality or obsessional rumination.[14]

In operant conditioning the individual emits some behavior already in his repertoire in order to obtain a reinforcement. Unlike respondent conditioning in which internal changes occur in response to antecedent stimuli, in operant conditioning behavior designed to change the environment occurs in response to consequent or reinforcing stimuli. For example, the young child may be trained to ask for a cookie (a response) in order to receive one (a positively reinforcing stimulus). For this operant conditioning to occur, the behavior of "asking" must exist in his repertoire, it must be emitted, and it must be followed by reinforcement. The reinforcement thus increases the probability of the response. The child might have demanded the cookie rather than asking. This response might have encountered the negative reinforcement of a scolding. To forestall such negative reinforcements in the future, the child might refrain from engaging in any conversations about cookies in the future (response suppression) or he might rely instead upon the prepotent behavior of asking. Through the differential application of positive and negative reinforcements, chains of complex behavior can be developed.

The complexity of behavioral chains can be increased when there is training in the discrimination of situations in which the response is likely to be reinforced. For example, the child might be trained to ask for a cookie when his mother is in the kitchen and not to ask when she is in the tub. Mother's presence in the kitchen sets the occasion for reinforcement, while her being in the tub sets the occasion for the nonoccurrence of reinforcement. Both situations are discriminative stimuli, the first setting the occasion for a response which may be met with reinforcement (S^D) and the second setting the occasion for a response which will not be reinforced (S^Δ).

Operant therapy,[15] based on the Skinnerean tradition, consists of the planful arrangement of environments so as to emit specific desirable behaviors. If operant behavior is maintained by its consequences, then alteration of these consequences must lead to alterations of behavior. The relevant environments might be as narrowly defined as the therapeutic situation or as broadly defined as the total institution. While some transfer of new behaviors is likely to occur, this can be facilitated through the planned extension of treatment through the programming of significant others. For example, if a child is to be taught to control his temper tantrums, his mother and perhaps his teacher must be trained in withholding positive reinforcement in the form of solicitous attention when tantrums occur.

Operant therapy can be used to extinguish maladaptive behavior, by

allowing it to occur without reinforcement. For example, to achieve extinction the child's mother might ignore his tantrums. Operant therapy can also be used to develop new adaptive behaviors through rewarding selective approximations of a behavioral goal. To achieve this "shaping" goal, the child's mother must positively reinforce each step which the child takes in the desired direction, being careful not to reinforce earlier steps or competing responses. There are many more paradigms of operant therapy, each of which is most generally likely to be effective when the influencee is aware of the objectives and when models of the desired behavior are available.[16]

Operant and respondent conditioning have each given rise to different therapeutic approaches because:

> "So far it has not been demonstrated that operant behavior controlled by its past consequences can be conditioned by means of Pavlov's formula, nor that respondent behavior can be manipulated by differential reinforcement contingencies."[17]

This suggests that the operant and respondent dimensions of each case must be analyzed separately. It does not, however, preclude the combination of the two approaches in a single case: indeed, many cases require such handling.[18]

Therapeutic Approaches

Given the role of the stimulus determinants of behavior, behavior

change can be understood as a process of altering responses to existing stimuli, altering the stimulus field or altering both responses and stimuli. These three broad approaches can be characterized as follows:

1. The client can learn to alter his responses to existing forces (stimuli) in the environment. For example, many young adults fear social contact with strangers: the sight of a group of unfamiliar persons is thus the stimulus for withdrawal. By learning to overcome this fear, this same group can become the stimulus for approach behavior with the expectation of making new friends.

2. The client can learn to alter his environment (stimulus field) so that existing behaviors can yield desired outcomes. For example, the handicapped worker who unsuccessfully strives for mastery in an occupation for which he is not equipped can change his area of endeavor. Through this change, the same behaviors which were maladaptive in one setting can achieve success in another setting.

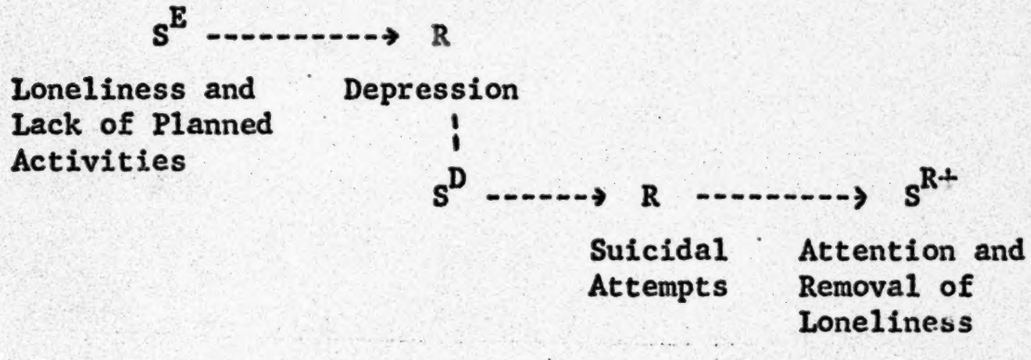
3. The client can learn to alter both his responses and his environment. In the complex situations handled by social workers, it is often essential to combine these approaches, in dealing with varied facets of the patient's problem. For example, the mother of a disturbed child might be trained to alter her response to his temper tantrums and might be encouraged to find outside activities to gratify her adult social needs. In other instances, the two approaches might be serially combined in handling a single problem situation, as with the psychotic patient being trained in how to respond to prospective employers and then being exposed to job-finding situations.

Case Illustration

Identifying Data: Miss AZ was an unmarried twenty-five year old secretary who was referred to Family Service for treatment by the Psychiatric Hospital.

Presenting Problem(s): Miss AZ was referred following hospitalization for a second suicidal attempt. After repair of severely cut arteries, she was discharged from the hospital with a diagnosis of "severe depression." As she viewed her problems, she had cut her wrists because she was very unhappy. Each time that she cut them, she was alone and had been alone for several days, was feeling very depressed and had no plans in the foreseeable future for any activity which might relieve her depression. Being alone and having no plans can be considered to be the eliciting stimuli for the response of depression.[19] Depression, in turn, can be considered to be the discriminative stimulus for the operant behavior of attempting suicide. The expected reinforcement for cutting her wrists was attention from the friend whom she called to help her and from the hospital attendants who treated her; such attention would remove the aversive stimulus of loneliness and also reinforce the suicidal acts.

The problem presented by Miss AZ can be diagramed as follows:



Treatment Goals: The referring hospital sought the prevention of future suicidal attempts. Miss AZ stated that her suicidal attempts were the result of dissatisfaction with her "work, social life ... everything." She wished to reach a point at which she would be free of depressive and suicidal ruminations, or at least be able to conquer them when they arose. She wished that she could be content with her job, could have friends other than the two middle-aged couples who were her only social contacts, and could be hopeful about her future.

Miss AZ's three problems, while assuredly interrelated, received somewhat differing treatments. Each problem will, therefore, be discussed separately.

Depression and Suicide: (1) Tentative projection of behavioral and environmental changes: Miss AZ had first to become able to control her ruminations when they occurred, and had then to learn to achieve satisfactions in her life sufficient to obviate depression. (2) Relevant conditions and treatment plan: Miss AZ expressed keen interest in religion, reading and knitting. As she described these prepotent behaviors, religion and reading were clearly dominant. Accordingly, she was given two tasks to perform when she anticipated depression when alone at home; these were to think about the glories of God and how she could help God's will to be done on earth, and to translate selected sections of the Bible and the Apocrypha into modern English. (3) Rationale: Miss AZ was trained to emit two kinds of operant behavior which would compete with depression. As she could not both glory in the works of God and be depressed, or concentrate upon the meaning of biblical passages and dwell upon her own loneliness, the treatment was systematically geared

to forestall depression. Reinforcement for the new responses stemmed from relief of the aversive experience of loneliness, positive reinforcement for depression-free periods by the therapist and energy to engage in other problem-solving activities.

Dull Work Situation: (1) Tentative projection of behavioral and environmental changes: Miss AZ had either to find new satisfactions in her current job or find new work. (2) Relevant conditions and treatment plan: Miss AZ was a trained stenographer but was employed as a posting bookkeeper. She found the work uninteresting and was frustrated by its lack of stimulation. Her goal was to find new secretarial employment involving creativity and social responsibility. She was hindered in attaining her goal because she "feared change" and because she feared that several job changes in the past would label her as a "poor employment risk." Her statement about fearing change was explored objectively (rather than receiving an "understanding" response from the therapist) and she was able to give up such statements immediately. She was then told that the local job market was such that persons of her skill were much in demand and that her work history would not deter employers. The criteria of jobs which would be interesting to her were reviewed and she was aided in determining what she would ask for. Finally she was asked to contact an employment agency within five days and to have at least two interviews within the next ten days. (3) Rationale: Miss AZ fortunately possessed skills much in demand. Had she not been skilled, treatment might have begun with aiding her to locate and undertake appropriate training. It was necessary to help her to overcome her inactivity which was maintained by negative expectations for herself

(fear of change) and for prospective employers (who would reject her because of her work history). She was encouraged to assert herself, a counter-conditioning procedure, and was reinforced in this effort with training in specific relevant behaviors (asking for exactly the kind of work which she wanted) and with relevant information about job availability. A schedule was set for her to enable her to overcome her tendency for inaction. Reinforcement for abiding by the timetable was furnished by the therapist in the form of abundant encouragement and praise, by her own sense that she was taking charge of her problems and by the promise of new rewards inherent in a new job.

Social Isolation: (1) Tentative projection of behavioral and environmental changes: Miss AZ complained of having no friends her own age and was so fearful of peer contacts that she constantly withdrew from young adults despite her intense desire to be with them. The steps to be taken to accomplish this goal were first becoming as attractive as possible, then locating peers, developing approach behaviors and developing behaviors appropriate to the maintenance of new friendships. (2) Relevant conditions and treatment plan: Miss AZ expressed herself well and was appropriately responsive to the therapist. She was somewhat unkempt and specific suggestions were made to improve her appearance. Short-term suggestions included changing her hair style and making her clothing more youthful and attractive. Long-term suggestions centered upon engaging her in a weight-reduction program.[20]

It was determined that she possessed basic social skills in ample supply, but that she lacked assertiveness necessary to put her in contact with peers. She was therefore given assertive training which consisted of having her approach one stranger in church and begin a two-sentence conversation, note exactly what aspect of the encounter was anxiety-arousing, and undergo counter-conditioning to overcome this barrier. She was interested in religion, reading, knitting and swimming and could use these interests to join groups in which she might encounter peers. Furthermore, she expressed an interest in attending college and was encouraged in this direction. As friendships arose, she was guided in means of developing them. During this experience, it was brought to light that since high school she had never maintained a close contact with a young person within ten years of her age. (3) Rationale: Miss AZ was encouraged to alter her appearance which was an important stimulus for the responses of others to her. For changes made in her appearance, she was reinforced first by the therapist, but more importantly by co-workers and, eventually, by friends. She was given counter-conditioning (assertive) treatment to overcome a respondent condition (anxiety) and then became able to emit a wide range of operant (social approach) behaviors.

Discussion

The main method throughout the treatment process was verbal instructions which served as discriminative stimuli ("mands" in Skinner's terms[21]) that set the occasions for the desired behaviors. Suggestions for new behaviors were carefully restricted to occasions in which success

was most probable. Success in the mastery of new situations was one important reinforcer for such activities. A second important reinforcer was considerable therapist encouragement prior to each step and praise following each success. A third type of reinforcement was "natural" in the sense that as Miss AZ succeeded in new areas, she created new opportunities for rewards inherent in these areas. A fourth type of reinforcement was the use of concrete rewards. When Miss AZ entered upon a weight reduction program, she was expected to lose an average of 1 1/2 pounds per week for twelve weeks. Each week in which she was successful in losing the predetermined amount of weight, her fee was reduced one third. She was to put this money in a special place and was to use it to purchase a new dress at the end of the three month period. These four types of reinforcement explain her "motivation" to participate in treatment aimed at solutions to her own problems.

Treatment for Miss AZ was designed to enable her to overcome numerous behavioral problems. Both operant and respondent procedures were used. Operant procedures are illustrated by training in the use of thinking about God, reading and writing as thought-stopping devices to relieve the stress of morbid ruminations. Other operant procedures ranged from therapist approval for her attempts to change her appearance to the recognition by others of her new, socially appropriate behaviors and the success which she encountered in finding a new job. Respondent procedures are illustrated by the training which she received in assertiveness in peer situations which replaced previous anxiety and withdrawal.[22]

One specific of the verbal interchange deserves special mention. At no time was Miss AZ allowed to ruminate about her sad lot in the presence of the therapist. Each time that ruminations began, she was asked to critically evaluate them. Not accepted, they were the subject of critical scrutiny, and their frequency rapidly diminished. In general, such behavior can be understood as operant behavior designed to yield attention.[23]

Treatment might have attempted to relieve her suicidal problem through discussion of the dynamics of her distress. This approach might have achieved success but had two distinct disadvantages. First, she would have been reinforced for continued self-preoccupation. Second, she would have been delayed in taking steps directly relevant to obtaining her objectives. Instead, treatment dealt exclusively with finding a means through which to achieve her goals, thereby helping her to overcome depression through the positive exercise of her capacity for choice.

Miss AZ changed rapidly. Within one week she had already found a new job which provided both more money and a satisfying variety of responsibilities. She began making an effort to extend her social contacts by joining church groups and eventually social groups. She then enrolled in college where she took evening courses for both educational and social returns. She gained no "insight" into inner conflicts through the treatment process although two other cognitive changes did occur. First, she acquired new labels for her maladaptive behavior. For example, depressed behaviors were "choices" rather than "inevitabilities." Second,

she learned to anticipate success rather than failure; that is, there was a shift in her verbalized expectations. It is probable that for two reasons the changes which she has made will be durable over time. First, she has learned reliable new procedures for self-management, procedures whose effect has been made clear to her through experience. Second, she has radically shifted her environment. Part of this shift is seen in alterations in her own behavior, an important element in her situation. Part, too, is found in the new people with whom she is in contact, and new circumstances such as at work and at school in which she finds herself. These new situations provide reinforcement for a new set of behaviors, and it was precisely these reinforcements which were lacking before she undertook therapy.

Conclusion

This paper has presented an overview of behavior therapy as it relates to the practice of social casework. The approach is goal directed and behaviorally specific. It is designed to maintain or change behavior through processes which are identical with the manner in which behavior is acquired. The range of techniques which is available is as broad as the range of problem descriptions. Each technique emphasizes alteration of the controlling conditions of behavior and each, therefore, depends upon precise specification of the problematic behavior, with its antecedent and consequent conditions.

While only one case illustration has been provided, the areas of possible application of the approach are legion. One logical early application can be found in the treatment of "unmotivated" clients who may be socially disadvantaged, severely maladaptive or strongly

disinterested in behavior change. With this group the techniques of behavior therapy provide a technology for promoting engagement in the treatment process. Further extensions might be made to public assistance programs (where recipients might be rewarded for finding jobs rather than punished by reductions in allowances); to correctional settings (where inmates might be rewarded for selective approximations of desired socially adaptive behavior); or to child guidance agencies (where parents might be trained through programming and modeling procedures in more effective child management, and where children might be offered training in the development of missing adaptive skills). There is virtually no area of social behavior not amenable to modification through the application of learning principles, and no setting where this approach cannot be used.

Footnotes

1. Leonard P. Ullmann and Leonard Krasner, "Introduction," in Leonard P. Ullmann and Leonard Krasner, eds., Case Studies in Behavior Modification (New York: Holt, Rinehart and Winston, 1965), pp. 1-63.

2. Charles B. Truax, "Reinforcement and Nonreinforcement in Rogerian Psychotherapy," Journal of Abnormal Psychology, Vol. 71, No. 1 (February, 1966), pp. 1-9.

3. Albert Bandura, "Psychotherapy as a Learning Process," Psychological Bulletin, Vol. 58, No. 2 (March, 1961), pp. 143-159.

4. See for example: H.J. Eysenck and S. Rachman, The Causes and Cures of Neurosis (San Diego: Robert S. Knapp, 1965).

5. Edward S. Sulzer, "Research Frontier: Reinforcement and the Therapeutic Contract," Journal of Counseling Psychology, Vol. 9, No. 3 (Fall, 1962), p. 271.

6. Joseph Wolpe and Arnold A. Lazarus, Behavior Therapy Techniques (Oxford: Pergamon Press, 1966), p. 17.

7. Arnold P. Goldstein, Kenneth Heller and Lee B. Sechrest, Psychotherapy and the Psychology of Behavior Change (New York: John Wiley, 1966), pp. 73-145.

8. C.B. Ferster, "Positive Reinforcement and Behavioral Deficits of Autistic Children," Child Development, Vol. 32, No. 3 (September, 1961), pp. 437-456.

9. Ogden R. Lindsley, "Characteristics of the Behavior of Chronic Psychotics as Revealed by Free-operant Conditioning Methods," in Theodore R. Sarbin, ed., Studies in Behavior Pathology (New York: Holt, Rinehart and Winston, 1961), pp. 74-87.

10. Arthur W. Staats and Carolyn K. Staats, Complex Human Behavior: A Systematic Extension of Learning Principles (New York: Holt, Rinehart and Winston, 1964), p. 477.

11. Thom Verhave, "Introduction," in Thom Verhave, ed., The Experimental Analysis of Behavior (New York: Appleton-Century-Crofts, 1966), p. 17.

12. W.N. Schoenfeld, "An Experimental Approach to Anxiety, Escape and Avoidance Behavior," in P.H. Hoch and J. Zubin, eds., Anxiety (New York: Hafner Publishing Company, 1964), pp. 70-99.

13. Joseph Wolpe, Psychotherapy by Reciprocal Inhibition (Stanford: Stanford University Press, 1958), p. 71.

14. The reader is urged to consult a review of behavior therapy such as the following: John M. Grossberg, "Behavior Therapy: A Review," Psychological Bulletin, Vol. 62, No. 2 (August, 1964), pp. 73-88.

15. For a comprehensive review of operant conditioning, see: Werner K. Honig, Operant Behavior: Areas of Research and Application (New York: Appleton-Century-Crofts, 1966).

16. Albert Bandura and Richard H. Walters, Social Learning and Personality Development (New York: Holt, Rinehart and Winston, 1963).

17. Verhave, op. cit., p. 17.

18. Arnold Lazarus et al., "Classical and Operant Factors in the Treatment of School Phobia," Journal of Abnormal Psychology, Vol. 70, No. 3 (June, 1965), pp. 225-229.

19. Depression is understood here to be an autonomic process and as such it is an illustration of respondent behavior. It is also recognized, however, that depression has operant properties such that certain negative affective expressions are emitted and certain classes of adaptive behaviors are not emitted. In both dimensions, the responses are under improper stimulus control and ameliorative responses are not reinforced by the environment. (See: C.B. Ferster, "Animal Behavior and Mental Illness," Psychological Record, Vol. 16, No. 1 [January, 1966], pp. 345-356.)

20. Richard B. Stuart, "Behavioral Control of Overeating," unpublished manuscript, 1967.

21. B.F. Skinner, Verbal Behavior (New York: Appleton-Century-Crofts, 1957).

22. Wolpe, op. cit.

23. Richard B. Stuart, "Casework Treatment of Depression Viewed as an Interpersonal Disturbance," Social Work, in press.